



CARESOURCE MEDICAID PROVIDER CLAIMS & BILLING GUIDE

2026 Indiana Health Coverage Programs (IHCP) Annual Seminar

Provider Education | October 6 – 8, 2026

Agenda

1

Claims Foundations

Forms, lifecycle, and eligibility

2

Submitting Your Claims

Methods, timely filing, and best practices

3

Denials & Resolution

Rejections, denials, and fixes

4

Adjustments & Coordination of Benefits (COB)

Corrections and other insurance

5

Disputes & Appeals

Claims Disputes, Appeals and Clinical Appeals

6

Prior Authorization (PA)

PA information and other important information

7

Important Resources and Contact Information

How to contact CareSource



PART ONE

Claims Foundations

The forms, the lifecycle, and who can bill

Claims Basics: Forms & Filing

The correct claim form depends on the type of provider and service billed.

Professional

Paper **CMS-1500**
Electronic **837P**

Physicians,
practitioners & other
non-institutional
providers.

Institutional

Paper **UB-04**
Electronic **837I**

Hospitals, facilities &
other institutional
providers.

Tip: Electronic submission is strongly encouraged



CMS-1500 Professional Claim Requirements

Purpose

- The HIPAA-compliant paper equivalent of the 837P professional transaction

Key fields to get right

- Box 24J - rendering provider National Provider Identifier (NPI); must link to the group NPI in Box 33a
- Box 33 - billing provider service address, including ZIP+4
- Box 33a - billing provider NPI (the correct field for professional claims)
- Box 33b - taxonomy that matches the group NPI enrollment

Corrected claims

- Enter 7 on the left side of Box 22 and the original claim number as the reference

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE ☐ **MEDICAID** ☐ **TRICARE** ☐ **CHAMPVA** ☐ **GROUP HEALTH PLAN** ☐ **FECA** ☐ **OTHER** ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **3. PATIENT'S BIRTH DATE** MM DD YY **4. INSURED'S NAME** (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) **6. PATIENT RELATIONSHIP TO INSURED** **7. INSURED'S ADDRESS** (No., Street)

8. CITY **9. STATE** **10. ZIP CODE** **11. TELEPHONE** (Include Area Code)

12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) **13. IS PATIENT'S CONDITION RELATED TO:** **14. INSURED'S POLICY GROUP OR PROGRAM NUMBER**

15. EMPLOYMENT? (Current or Previous) **16. INSURED'S DATE OF BIRTH** MM DD YY **17. OTHER CLAIM ID** (Designated by NUCC)

18. AUTO ACCIDENT? **19. OTHER ACCIDENT?** **20. INSURANCE PLAN NAME OR PROGRAM NAME**

21. IS THERE ANOTHER HEALTH BENEFIT PLAN? **22. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

23. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE **24. DATE** **25. SIGNED**

26. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (EMP) **27. OTHER DATE** **28. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

29. NAME OF REFERRING PROVIDER OR OTHER SOURCE **30. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

31. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **32. OUTSIDE LAB?** **33. CHARGES**

34. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY **35. ICD-9-CM** **36. SUBMISSION CODE** **37. ORIGINAL REF. NO.**

38. PRIOR AUTHORIZATION NUMBER **39. DATE(S) OF SERVICE** **40. PLACE OF SERVICE** **41. PROCEDURE, SERVICE, OR SUPPLY** **42. DIAGNOSIS POINTER** **43. CHARGES** **44. DATE OF SERVICE** **45. TEST PERFORMED** **46. ID. QUAL.** **47. RENDERING PROVIDER ID. #**

48. FEDERAL TAX ID. NUMBER **49. SSN/EIN** **50. PATIENT'S ACCOUNT NO.** **51. ACCEPT ASSIGNMENT?** **52. TOTAL CHARGE** **53. AMOUNT PAID** **54. PAID FOR NUCC USE**

55. SIGNATURE OF PHYSICIAN OR SUPPLIER **56. SERVICE FACILITY LOCATION INFORMATION** **57. BILLING PROVIDER REF. #**

58. SIGNED **59. DATE** **60. NPI** **61. NPI** **62. NPI** **63. NPI** **64. NPI** **65. NPI**

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED-COMB-09/06-11/07 FORM 1500 (02-12)



UB-04 Institutional Claim Requirements

Purpose

- The Health Insurance Portability and Accountability Act (HIPAA) compliant paper equivalent of the 837I institutional transaction

Key requirements

- Field 56 - billing provider NPI
- An appropriate revenue code describing the service or setting
- Type of Bill (TOB) and admission type (1- Emergency, 2 - Urgent, 3 - Elective, 4 - Newborn)
- Up to 27 diagnosis codes accepted

Corrected / replacement claims

- Use a TOB frequency code 7 (field 4) and the original claim number in field 64

The image shows a UB-04 Institutional Claim form, which is a standardized paper form used for submitting institutional claims to health insurance payers. The form is color-coded with orange and yellow sections. A large 'SAMPLE' watermark is visible across the center. The form includes sections for patient information, insurance details, and medical services. The bottom section includes a summary of charges and a signature area.



The Claim Lifecycle

1

Verify Eligibility

Confirm member enrollment and coverage before the date of service.

2

Submit Claim

File electronically (837) or on paper within the timely filing limit.

3

Adjudication

The claim is reviewed against benefits, coding, and payment policy.

4

Payment or Denial

Approved claims are paid; issues generate a denial with a reason code.

5

Adjustment or Appeal

Correct and resubmit or appeal a denial within the allowed window.



Claims Submission Fundamentals

Before you bill

- Verify member eligibility at every visit, prior to rendering services
- Confirm the correct payer - CareSource Medicaid Electronic Data Interchange (EDI) Payer ID **INCS1**
- Include NPI, Tax Identification Number (TIN), and taxonomy on every claim

Submit a clean claim

- Ensure claim is complete, accurate, and free of errors or missing information
- Include all required attachments related to the claim submitted.
 - Examples: Primary Explanation of Payment (EOP), Sterilization Form, Hysterectomy Form, Invoices, Itemized Statements

File claim timely

- Ensure the claim is submitted within 90 calendar days of the date of service



Eligibility and Enrollment

Why It Matters

- Medicaid eligibility can change from month to month.
- Members may be assigned to a different health plan than expected.
- Verify on the date of service, not only at scheduling.
- Unverified coverage is a leading cause of claim denials.

How to Verify

- Use the [IHCP Provider Healthcare Portal](#), for real-time checks.
- Use the [CareSource Provider Portal](#) member lookup.
- 270/271 electronic eligibility transaction.



Provider Enrollment: How it Affects Your Claims

Enroll before you bill

- Providers must be actively enrolled with the IHCP for the date(s) of service
- The group taxonomy must match what is listed in Core MMIS/the IHCP provider portal
- Rendering providers must be linked to the billing group NPI and active for the date of service

Keep your information current

- Update address, ownership, licensure, and group affiliations with the IHCP Provider Enrollment Unit
- The service address on the claim, including ZIP+4, must match the group NPI enrollment

Why it matters

- Enrollment mismatches are a leading cause of one-to-one match and NPI rejections



PART TWO

Submitting Your Claims

Methods, timely filing, and best practices

3 Ways to Submit Claims to CareSource

1

Electronically

- EDI transaction sent to CareSource through Availity. For list of EDI vendors who transmit to Availity EDI Gateway, click [here](#).
- CareSource Payer ID **INCS1**
- Availity's Client Services
1-800-282-4548
Monday – Friday, 8 a.m. – 8 p.m. Eastern Time (ET)

2

Portal

- Medical claims can be keyed on the [CareSource Provider Portal](#).
- Medical Claim forms (*CMS-1500/UB-04*) can be uploaded.
- Upload attachments for both keyed claims and uploaded claims forms.

3

Mail

- Ensure printing is aligned to the form and legible.
- Paper claims have the same NPI, TIN, and taxonomy code requirements as electronic claims.
- Mail claims to: **CareSource**
Attn: Claims Department
P.O. Box 3607
Dayton, OH 45401



Timely Filing

Scenario	Filing Limit
Participating providers	90 calendar days from date of service or discharge
Out-of-network providers	90 calendar days from date of service or discharge
Coordination of benefits (COB)	90 calendar days from the primary payer EOP date
Corrected claims	60 calendar days from the date of the EOP to submit a corrected claim
Newborns (0-30 days of life)	Same timely filing guidelines apply for newborns. <u>Newborns</u> receiving retroactive coverage are not subject to timely filing requirements
Retroactive member eligibility	Timely filing limit is extended to one year from the date eligibility was established.



Claim Attachments

If your claim requires an attachment when submitting, please ensure that you include that information with your claim.

Examples of Attachments:

- Primary Insurance EOP
- Sterilization Form – [Consent for Sterilization: Form HHS-687](#)
- Hysterectomy Form – IHCP provider reference module - [Obstetrical and Gynecological Services](#) – Figure 1
- Invoices
- Itemized Charges for high dollar claims - [High Dollar Claims Network Notification](#)

If you are unable to attach at the time of submission, you can attach the required information to your claim via the [CareSource Provider Portal](#).



Best Practices for Clean Claims



Verify eligibility on every date of service.



Use current, valid Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases- Tenth Revision (ICD-10) codes.



Include the correct NPI, taxonomy, and member ID.



File electronically and within timely filing limits.



Attach required documentation and authorizations.



Reconcile remittance advice and rework denials promptly.



PART THREE

Denials & Resolution

Rejections, denials, and how to fix them

Rejected, Denied & Voided

These three outcomes are different — and each requires a different response.

Rejected

Failed initial edits before processing — missing or invalid data.

Action: Correct and resubmit as a new claim; timely filing still applies.

Denied

Processed but not paid due to a coverage, coding, or policy issue.

Action: Read the reason code, then correct and resubmit or appeal.

Voided

A previously paid claim reversed or cancelled, often to correct an error.

Action: Submit a corrected replacement claim with the right information.



Common Denials & Fixes

Common Reason	How to Prevent or Fix
Member not eligible on the date of service	Verify eligibility before every visit
Duplicate claim submitted	Check claim status before resubmitting
Missing or invalid PA	Obtain and reference the PA number
Invalid or outdated procedure/diagnosis code	Use current CPT, HCPCS, and ICD-10 codes
Timely filing limit exceeded	File within the window and keep proof
Coordination of benefits not applied	Bill the primary payer first and attach their EOP



Common Rejection & Enrollment Errors

Common Error	How to Prevent It
One-to-one match/NPI (CMS-1500 boxes 24J, 33, 33a/b)	Link the rendering provider to the group NPI and confirm rendering provider is active for the date of service
Service address / ZIP+4 mismatch	Use the group NPI service address, including ZIP+4, in Box 33
Taxonomy mismatch	Match the Box 33b taxonomy to the group NPI enrollment
Invalid NPI, taxonomy, or ZIP+4 (returned to provider)	Verify the billing NPI is in the correct field and format (<i>UB-04</i> field 56 / <i>CMS-1500</i> Box 33a)
Missing primary EOP (COB)	Attach the primary payer EOP and resubmit as corrected within 90 calendar days of the primary payment
Duplicate claim	Add corrected-claim indicators; do not rebill a clean claim



Preventing Common Billing Errors

Before the visit

- Verify member eligibility for every date of service
- Confirm PA is on file when required

On the claim

- Match NPI, TIN, and taxonomy to IHCP enrollment
- Confirm the rendering provider is linked to the group and active for the date of service
- Use the correct claim form and revenue / procedure codes

On time & complete

- File within 90 calendar days from the date of service or discharge
- Attach the primary EOP for COB
- Never bill members for covered Medicaid services or balance bill



PART FOUR

Adjustments & Coordination of Benefits (COB)

Corrections & other insurance

Adjustments & COB

Adjustments & Corrections

- Use a corrected (replacement) claim to fix a paid claim.
- Use the most recent version of the claim number when making the correction.
- Do not file a brand-new claim to fix one — it may deny as a duplicate.
- Void a claim only to cancel one billed in error.

Coordination of Benefits

- Medicaid is the payer of last resort.
- Bill other insurance (commercial or Medicare) first.
- Attach the primary payer's EOB to the CareSource claim.
- File COB claims within the timely filing window.



Claim Adjustments: Voids, Replacements & Corrected Claims

Corrected / replacement claims

- Submit within 90 calendar days from the date of service or discharge
- *UB-04*: Type of Bill frequency code 7 (field 4) plus the original claim number in field 64
- *CMS-1500*: enter 7 in the left of Box 22 plus the original claim number
- Without these indicators, the claim processes as an original or denies as a duplicate

Voids & overpayments

- Voided claims cannot be disputed or appealed
 - Claim will need to be resubmitted and still counts towards the timely filing guidelines



What to do with a Corrected Claim

Corrected claims should be sent through EDI or mailing a red and white claim form and the primary insurance EOP to:

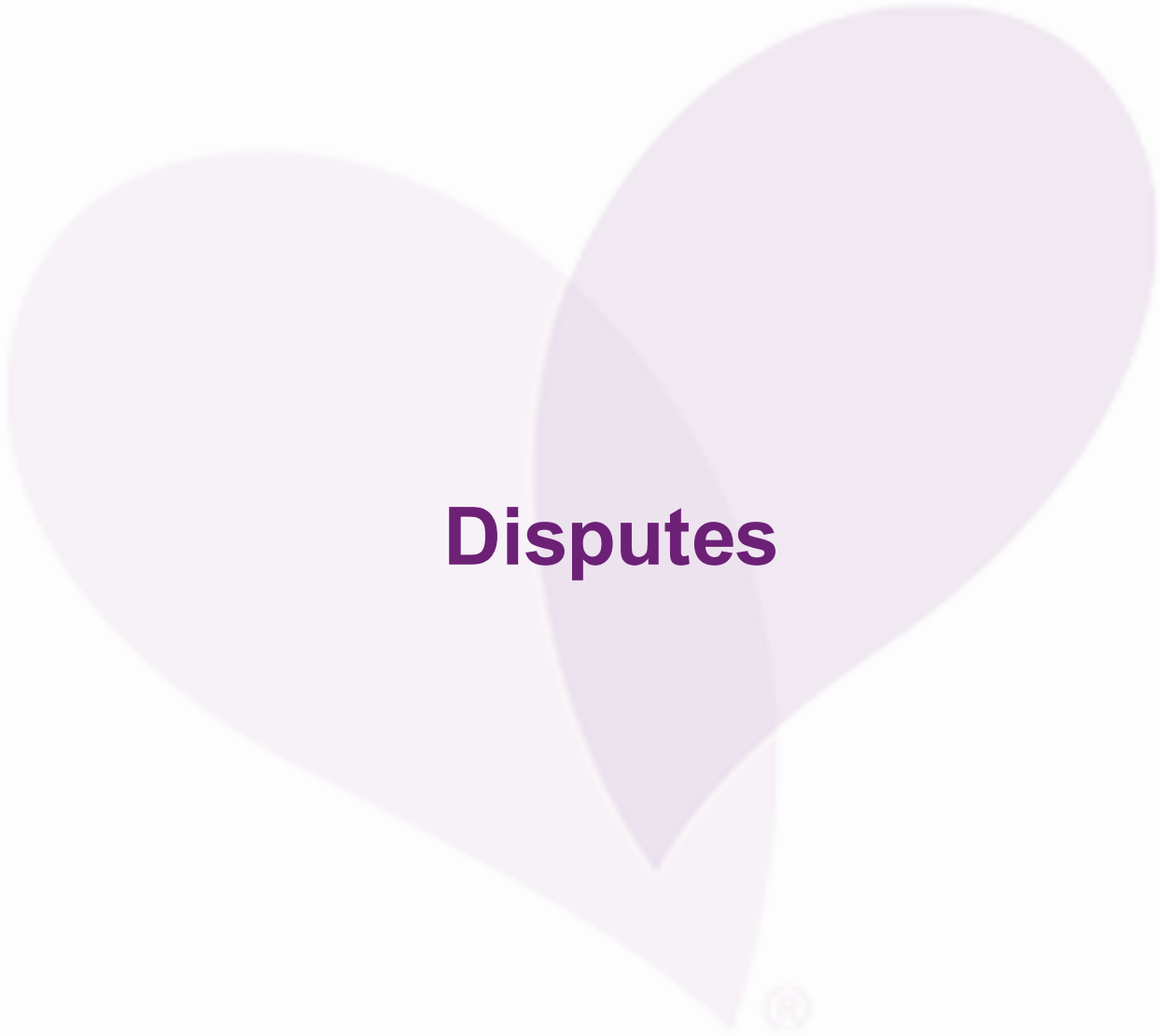
CareSource Claims Department
P.O. Box 3607
Dayton, OH 45401-3607



PART FIVE

Disputes & Appeals

Claims Disputes, Appeals and Clinical Appeals



Disputes



Definition of a Claims Dispute



A dispute is the **first** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is submitted prior to submitting a claim appeal.

You can submit a claim payment dispute when you disagree with payment and any other post-service claim denial.



Key Information to Include with Dispute



List reason claim/line should be paid.



Provide supporting documentations i.e. IHCP Bulletin, IHCP Provider Reference Module, Policy, Manual.



Include medical records.*

***NOTE:** If your claim was denied requesting medical records, those should be submitted via the [CareSource Provider Portal](#).



Timeframe to Dispute



Ways to Submit a Claims Dispute

1

Portal

The preferred method of submission is through the [CareSource Provider Portal](#).

2

Postal Mail

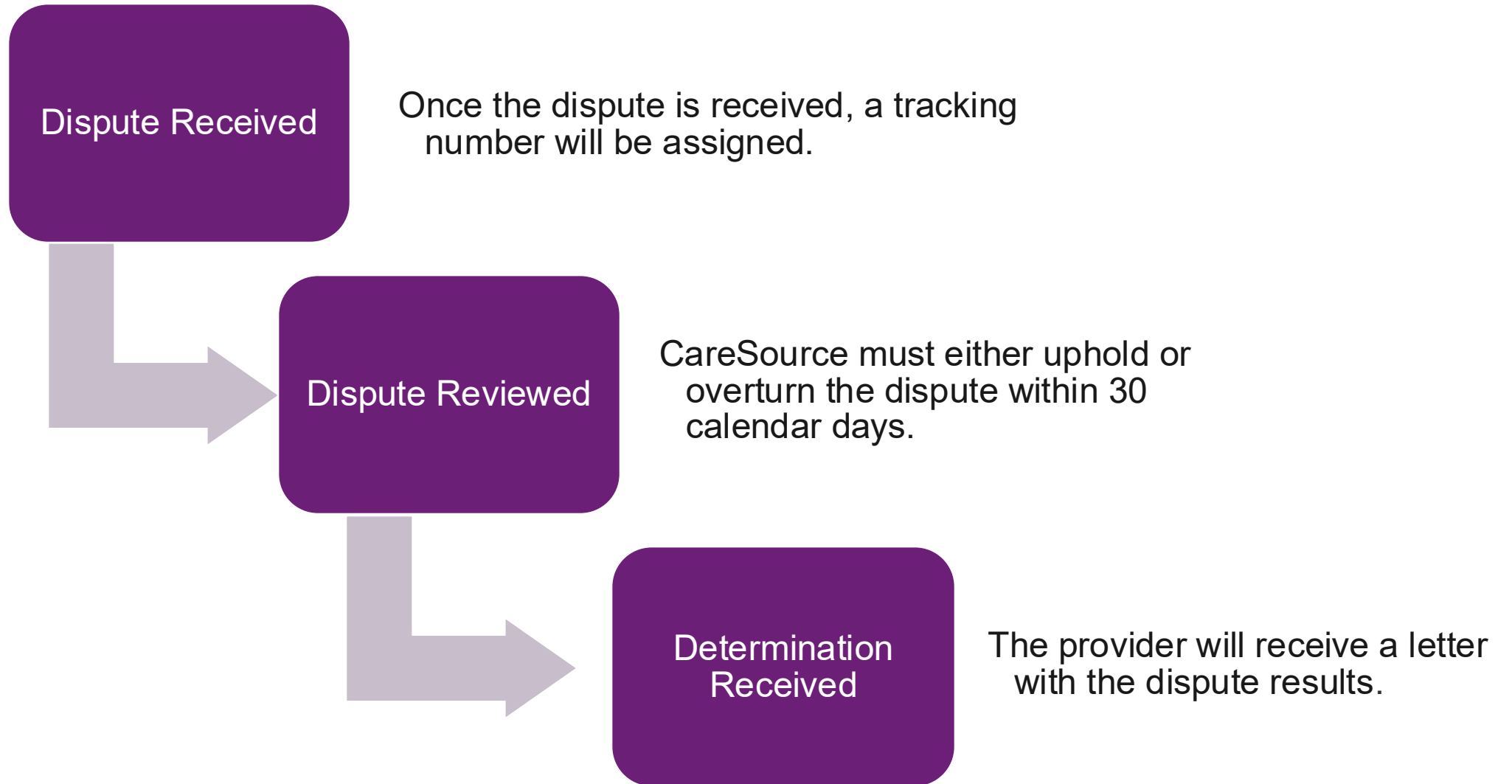
CareSource Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

Submit [dispute form](#) along with documentation to substantiate reason for dispute.

For questions, please call CareSource Provider Services at 1-844-607-2831, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET)



CareSource Dispute Process





Claim Appeals



Definition of a Claims Appeal



An appeal is the **second** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is submitted after submitting a claim dispute.

You can submit a claim payment appeal when you disagree with payment and any other post-service claim denial.

Providers must exhaust the claim dispute process as outlined above before filing a claim appeal.



Key Information for a Claims Appeal

Appealing on Member's Behalf:

- If filing an appeal on behalf of a member or for pre-service issues, the member's written consent, which must be specific to the service being appealed, is only valid for that appeal and must be signed by the member.
- You can use the [Consent for Provider to File an Appeal on Patient/Member's Behalf](#) form to record this consent.



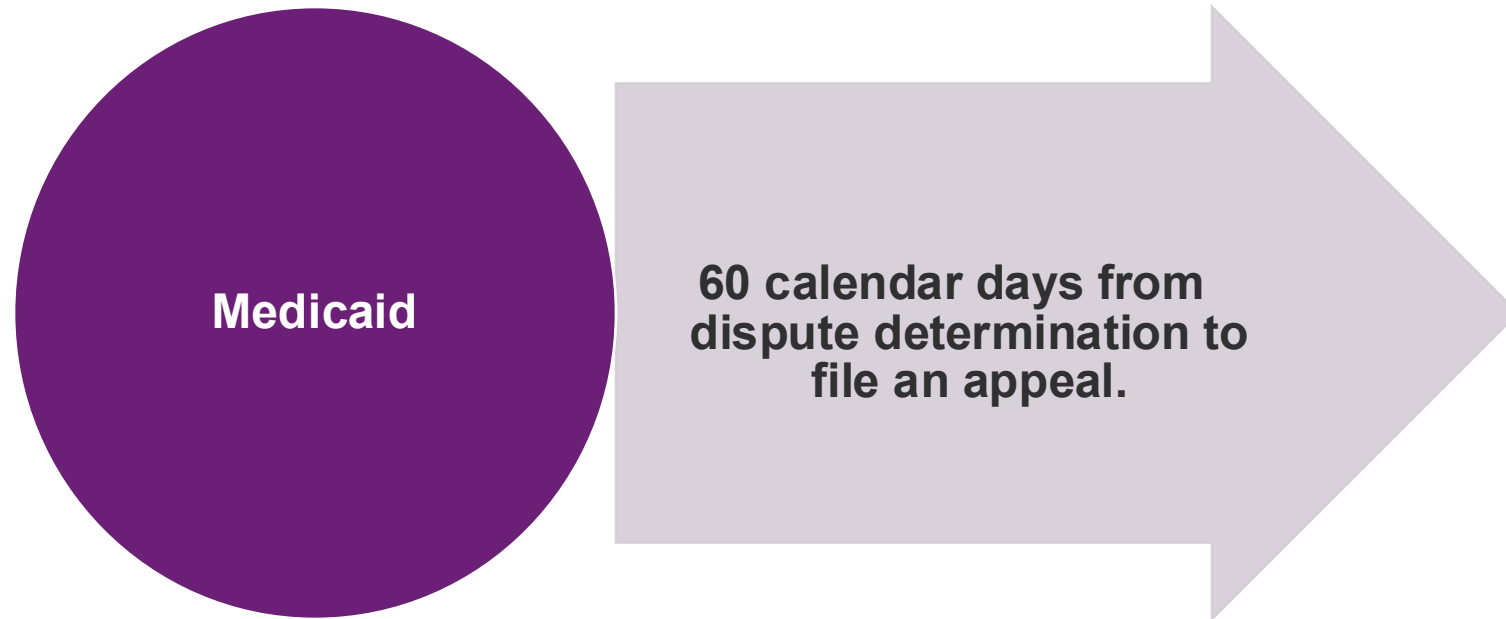
Key Documentation to Include in a Claims Appeal

Include the following required documentation:

- Progress notes including symptoms and their duration, physical exam findings, conservative treatment that the member has completed, preliminary procedures already completed, and the reason service is being requested.
- Any documentation of specialists' reports or evaluations, any pertinent previous diagnostic reports and therapy notes.
- If the service has already been provided, a copy of the original remittance advice and/or the denied claim.
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.



Timeframe to Appeal



Ways to Submit a Medicaid Claims Appeal

1

Portal

The preferred method of submission is through the [CareSource Provider Portal](#).

2

Postal Mail

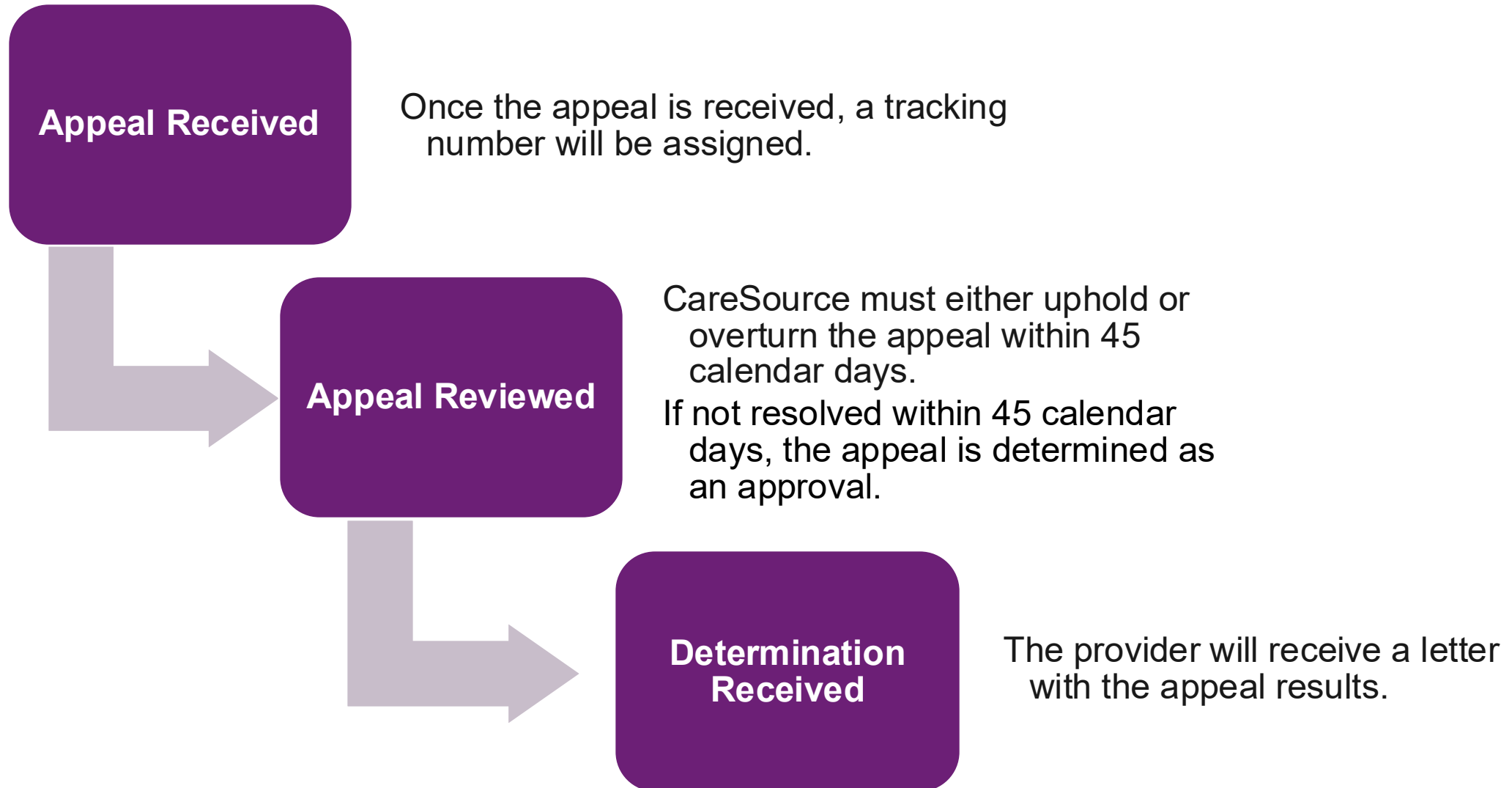
CareSource Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

Submit [appeal form](#) along with documentation to substantiate reason for appeal.

For questions, please call CareSource Provider Services at 1-844-607-2831, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET)



CareSource Appeal Process





Clinical Appeals



Definition of a Clinical Appeal



A clinical appeal is a written request by a provider to review a prior authorization denial with a clinical decision regarding medical necessity. Clinical denials are issued from the CareSource Utilization Management department.

All appeal requests and associated information are reviewed by clinicians not previously involved with the case.



Medicaid Clinical Appeal of a PA Denial

Pre-Service

Must be submitted with written member consent.

Must be submitted within 48 hours from the date of action notice to submit a pre-service appeal.

If a delay in the care decision could put your patient's life or health at risk, you may request an expedited clinical appeal. Call 1-844-607-2831 (Mon–Fri, 8 a.m.–8 p.m.) or mail an [Expedited Appeal Form](#).

Post-Service

Must be submitted with written member consent.

Must be submitted within 48 hours from date on the notice of action, discharge or authorization-denial.

If you have not received an authorization denial from the CareSource Utilization Management Department for a service that requires a prior authorization, you must submit a retro-authorization request prior to filing a clinical appeal.



Notification of Resolution

CareSource will decide whether to expedite an appeal within 48 hours*. We will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal; the attempt will be made by phone.

Expedited appeals will be resolved, and verbal notification will be made within 48 hours* of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution time frame is extended. CareSource will send written notification to both the provider and the member on the same business day of the decision.

*Does not include weekends and state and federal legal holidays.



Extending a Clinical Appeal

Members may verbally request that CareSource extend the time frame to resolve any medical necessity appeal request up to 14 calendar days. CareSource may also request an extension.

CareSource will provide a written notice for the extension.



External Review for a Clinical Appeal

CareSource members can request an external review and state hearing concurrently after they have exhausted all CareSource's internal appeals process. The member or a member's representative must submit the request, with member consent, in writing within 120 calendar days from the date of the appeal decision. The IRO will decide to uphold or reverse the decision within **72 hours for an expedited appeal, or 15 business days for a standard appeal**. The determination made by the independent review organization is binding.

To request an external review the member can write to CareSource at:

CareSource

P.O. Box 8738

Attn: External Review

Dayton, OH 45401-8738

Fax: 844-417-6262 - Attn: Independent Review – Appeals Dept.

The request for a state fair hearing must be sent to the State of Indiana Office of Administrative Law Proceeding at:

Office of Administrative Law Proceedings

100 N. Senate Avenue Suite N802

Indianapolis, IN 46204



PART SIX

Prior Authorization (PA)

Authorizations and Important PA information

Prior Authorization Definition

Prior authorization is a review process used by managed care organizations (MCO's) to determine if a specific medical service, medication, or procedure is eligible for coverage under a patient's plan.

- CareSource evaluates prior authorization requests based on medical necessity, medical appropriateness, and benefit limits.
- Emergency care does not need prior authorization.
- If the provider is not part of the CareSource network, a prior authorization **must be obtained before any services** are rendered.

Reminder: An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding, eligibility, and benefits.



Prior Authorization

When PA Is Required

- Hospital stays and surgical procedures.
- Certain high-cost medications and specialty care.
- Advanced imaging studies such as MRI, CT, and PET.
- Care delivered outside the network.
- Durable Medical Equipment (DME) that exceeds established limits.

How to Request

- Submit through the CareSource Provider Portal.
- Include clinical documentation and medical necessity.
- Request before the service is rendered.
- Reference the PA number on the claim.
- Emergency services do not require prior authorization.



Procedure Code Lookup Tool

Refer to the [Procedure Code Lookup Tool](#) to check whether a service requires prior authorization.

Prior authorization requirements may differ between [Healthy Indiana Plan](#) and [Hoosier Healthwise](#).



Procedure Code Lookup

Is this for an inpatient or outpatient service? *

Outpatient

OR

Inpatient

Inpatient services are medical care that requires a patient to stay in a healthcare facility for a period, usually a few days.

Line of Business

Line of Business *

Indiana Medicaid

Service Date *

10/07/2026

Today

Enter or select the date the service was provided.

Procedure Code(s) *

70551

Enter one or more CPT/HCPCS codes, separated by commas (e.g., 99213,99214).

Search

Results as of service date 10/07/2026

Code 70551

Description "Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material"

Procedure Code	Modifiers	Procedure Code Termed	Auth is required?	Description	Place of Service	Age Range (Min-Max)	Vendor Name	Instructions
70551	-	No	No	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	-	-	Evolut	Providers should contact Evolut or their web portal at www.radmd.com.

Effective Date

4/1/2021 12:00:00 AM

Expiration Date

12/31/9999 11:59:59 PM

Service Start Date

10/7/2026 12:00:00 AM

Service End Date

10/7/2026 12:00:00 AM

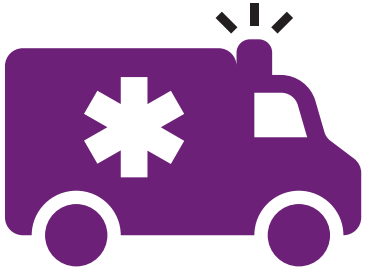


DISCLAIMER CareSource does not represent or warrant, whether expressed or implied, including but not limited to, the implied warranties of merchantability and fitness for a particular purpose the results of the Procedure Code Prior Authorization Lookup Tool ("Results"). Results are provided "AS IS" and "AS AVAILABLE" and do not guarantee approval or payment for services. Approval or payment of services can be dependent upon the following, but not limited to, criteria: member eligibility, members <21 years old, medical necessity, covered benefits, modifiers, diagnosis and revenue codes, limits and number of visit variances, provider contracts, provider types, correct coding and billing practices. For specific details, please refer to the [Health Partner Provider Manual](#) on the CareSource website. If you are unsure whether or not a prior authorization is required, please refer to [Health Partner Policies](#) or the [Prior Authorization](#) page on the CareSource website.

- **Please Note:** All non-emergent inpatient services require prior authorization.
- All emergent inpatient services require authorization.
- All non-participating provider requests require prior authorization.
 - For Indiana Medicaid:
 - Services specified as self-referral services do not require prior authorization for out-of-network (OON) providers.
 - Prior authorization may be required for additional services based on code.
- Visit our [Pharmacy](#) webpage for more details on drugs that require prior authorization.
- Reference our [Dental Provider](#) Manual for dental services that require prior authorization.



Non-Participating Providers



Prior authorization must be obtained before sending patients to **non-participating providers**, with the exception of **Emergency Services**.

Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a non-participating provider.

All **non-participating providers** and all requests for **inpatient services** require prior authorization.



To request prior authorization as a non-participating provider or to request authorization for any inpatient admission, call **1-844-607-2831** (Monday – Friday, 8 a.m. – 5 p.m. ET) and follow the appropriate menu prompts. During regular business hours, your call will be answered by our Utilization Management department.

Note: Non-participating providers must be IHCP-enrolled to receive reimbursement and claims must be submitted within 90 calendar days from date of service or discharge.



Evolut

CareSource partners with Evolut to implement our radiology benefit management program for outpatient advanced imaging services.

Procedures which
require prior
authorization
through Evolut:

Refer to the [Procedure
Code Lookup Tool](#) to
determine services
authorized by Evolut

Services which **do
not** require
prior authorization
through Evolut:

Inpatient Advanced
Imaging Services

Observation

Emergency room
imaging services

Evolut
Authorization phone
and website
information:

1-800-424-4883
8a.m. – 8p.m. ET
[Welcome to
RadMD.com | RADMD](#)
Urgent/Expedited
authorizations – contact
the Evolut Provider
Support Team



Prior Authorization Electronic Submission

<u>CareSource Provider Portal</u> (Preferred)	You can receive immediate approval and review the status of an authorization. For assistance with submitting your prior authorization or questions regarding submissions via the portal, email CiteAutoAssistance@caresource.com, and a representative will be in contact. This email is only for assistance and questions regarding prior authorizations within the Provider Portal.
FAX	Medical: 1-844-417-6157 Behavioral Health: 1-937-487-1664 Neonatal Intensive Care Unit Requests: 1-937-396-3499

Faxed requests should be submitted using the [IHCP Medical Prior Authorization Request Form](#).



PA Timeframes

Authorization Type	Decision	Extension
Standard Pre-Service	Forty-eight (48) business hours* <i>Excludes weekends and holidays</i>	Fourteen (14) calendar days
Urgent Pre-Service	Twenty-four (24) business hours* <i>Excludes weekends and holidays</i>	Fourteen (14) calendar days
Urgent Concurrent	Forty-eight (48) hours	No extension
Post-Service (Retrospective Review)	Thirty (30) calendar days	No extension
Approved Authorization	Valid for 365 calendar days	N/A

To check the status of a prior authorization request call **844-607-2831** or log into the [Provider Portal](#).





Retro-Authorization



Medicaid Retro Authorizations Guidelines

Upon written request, CareSource shall not permit retro authorization submission after the date of service or admission where a prior authorization was required but not obtained **except** in the following circumstances as outlined in section two of the IHCP Provider Reference Module for [Prior Authorization](#).



Retro Authorizations

Prior Authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

- Pending or retroactive member eligibility. The prior authorization request must be submitted within 12 months of the date when the member's caseworker entered the eligibility information.
- Mechanical or administrative delays or errors by the contractor or county office of Family and Social Services Administration (FSSA) Division of Family Resources (DFR).
- Services rendered outside Indiana by a provider that had not yet enrolled as an IHCP provider.
- Transportation services to or from an out-of-state area or rendered by a provider located out of state or by an airline or air ambulance. The prior authorization request must be submitted within 12 months of the date of service.



Medicaid Retro Authorizations – Unaware of Coverage

The provider was unaware that the member was eligible for services at the time services were rendered.

Prior authorization will be granted in this situation only if the following conditions are met:

- The provider's records document that the member refused or was physically unable to provide the IHCP Member ID (MID) number.
- The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
- The provider submitted the request for prior authorization within 60 calendar days of the date Medicaid eligibility was discovered.



Retro Authorization Timeframes

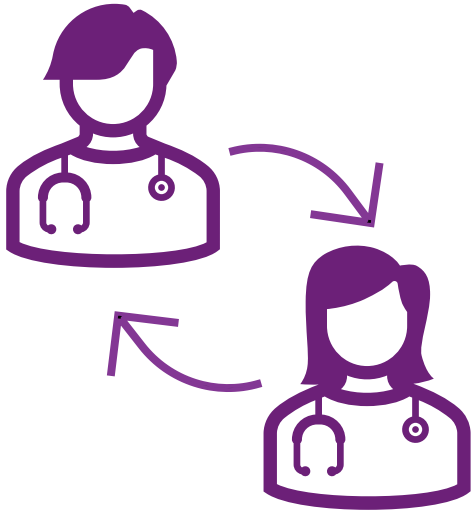


Retrospective (post-service) reviews will be decided within **30 calendar days** from the receipt of the request.

If a provider's service changes during a procedure, you must call or fax CareSource immediately to seek a change in your Prior Authorization or request a retro auth if the original service did not require one.



Peer-to-Peer Review for Denied PA



Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations.

If you would like to discuss a case with the Clinical Peer Reviewer, please contact the Utilization Management Department.

By Phone at **1-844-607-2831 ext. 1283**

By Fax at **1-844-432-8924**

You must contact CareSource within **seven (7)** business days of the determination.

Our new line was created with a special team dedicated to answer live calls. You will be able to reach a live staff member anytime during hours of 8 a.m. to 5 p.m. ET.

[CareSource Indiana Provider Manual](#) > Utilization Management



PART SEVEN

Important Resources and Contact Information

Stay Current

Key Areas to Watch

- Annual CPT, HCPCS, and ICD-10 code updates — review new and deleted codes.
- Continued shift toward electronic claims and portal transactions.
- Updates to prior authorization requirements and code lists.
- Fee schedule and reimbursement policy refreshes.
- Read [IHCP bulletins](#) for updates and changes.
- Sign up for CareSource [Updates and Announcements](#) notifications.

Review IHCP bulletins and CareSource Network Notifications on a regular basis. To update your billing workflows before changes, take effect.



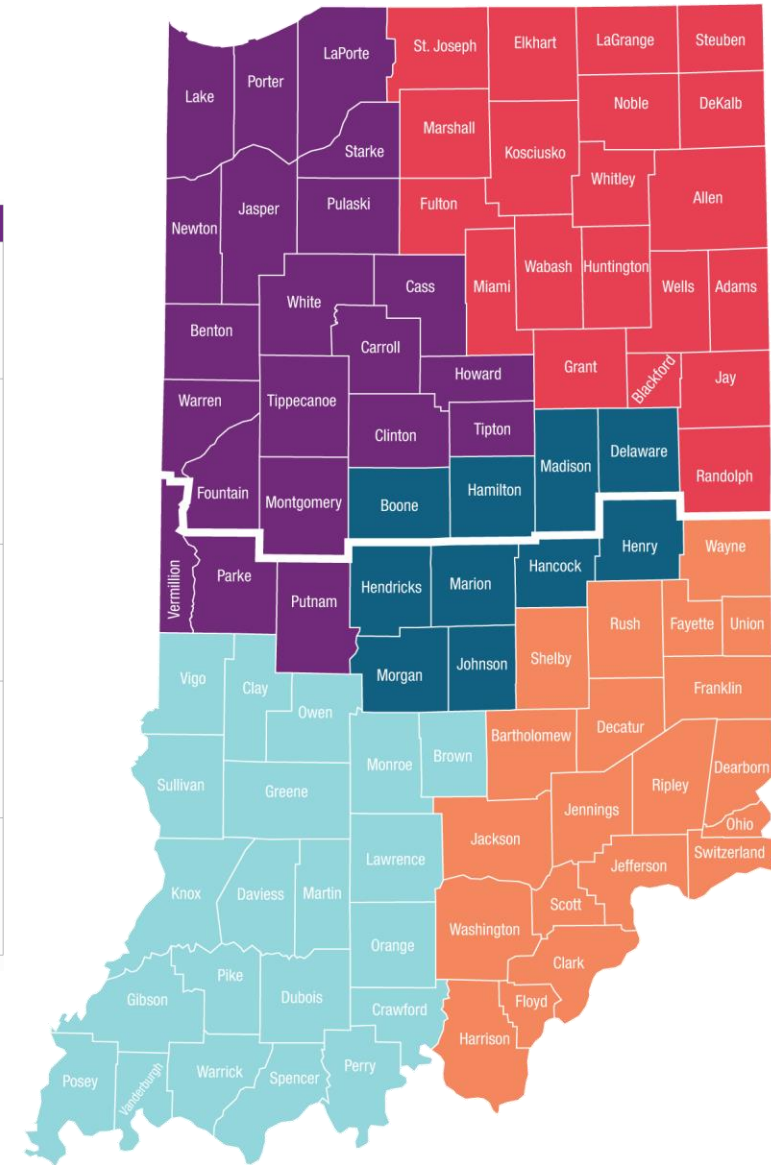
Communicating with CareSource

Provider Services		
Medicaid	1-844-607-2831	Monday to Friday 8 a.m. to 8 p.m. (ET)
Member Services		
Medicaid	1-844-607-2829	Monday to Friday 8 a.m. to 8 p.m. (ET)



Health Partner Engagement Representatives – Regional Specialist

Specialist	Counties	Health Systems
Danyelle Pittman North West 463-327-2297 Danyelle.Pittman@CareSource.com	Lake, Porter, LaPorte, Newton, Jasper, Starke, Pulaski, Benton, White, Cass, Warren, Tippecanoe, Carroll, Clinton, Howard, Tipton, Fountain, Montgomery, Vermillion, Parke and Putnam	Methodist, Powers Health, American Health Network, Lurie Children's Hospital, Iroquois Memorial Hospital, University of Chicago, Woodlawn Memorial Hospital and Putnam County Hospital
Leigh Hoover North East 765-425-0462 Leigh.Hoover@CareSource.com	St. Joseph, Elkhart, LaGrange, Steuben, Marshall, Kosciusko, Noble, DeKalb, Whitley, Allen, Fulton, Miami, Wabash, Huntington, Wells, Adams, Grant, Blackford, Jay and Randolph	Beacon Hospital Systems, Select Health Network, St. Joseph Regional Medical Center, Adams County Hospital, Goshen Health, Cameron Hospital, Select Physical Therapy, Lutheran Health Network and Marion General Hospital/Physicians
Amy Dagon West Central 317-417-9652 Amy.Dagon@CareSource.com	Boone, Hamilton, Hendricks, Marion, Morgan, Johnson, Madison, Delaware, Hancock and Henry	Hendricks Regional Health, Johnson Memorial Hospital, Henry County Hospital/Physicians and Hancock Regional Hospital/Physicians
Paula Egan South West 812-447-6661 Paula.Egan@CareSource.com	Clay, Owen, Monroe, Sullivan, Greene, Lawrence, Knox, Daviess, Martin, Gibson, Pike, Dubois, Orange, Posey, Vanderburgh, Warrick, Spencer, Perry, Crawford, Vigo and Brown	Good Samaritan Hospital, Daviess County Hospital, Greene County General Hospital, Perry County Memorial Hospital, Union Hospital/Physicians and Terre Haute Regional
Bonnie Waelde South East 812-480-9203 Bonnie.Waelde@CareSource.com	Bartholomew, Decatur, Franklin, Jackson, Jennings, Ripley, Dearborn, Washington, Scott, Jefferson, Switzerland, Ohio, Harrison, Floyd, Clark, Shelby, Rush, Wayne, Fayette and Union	Columbus Regional Hospital, Baptist Health – Floyd, Decatur County Memorial, Norton Healthcare, Major Hospital/Physicians, Scheck Memorial Hospital and Rush Memorial Hospital/Physicians



CareSource Health Partner Engagement Team



Health Partner Engagement Representatives – Statewide Specialists

Sarah Tinsley

Health Partner Engagement Specialist III
317-607-4844

Sarah.Tinsley@CareSource.com

Statewide Health Systems:

IU Health, Deaconess, Eskenazi, Ascension St. Vincent and Witham Health Services, Urgent Dental Center, D2 Dental, Kids and Adult Dental, Heartland Dental and Familia Dental

Tammy Garrett

Health Partner Engagement Specialist III
219-221-7065

Tammy.Garrett@CareSource.com

Statewide Health Systems:

Community Health Network, Franciscan Health Alliance, Parkview Health, Reid Health, Riverview Health, Ladd Dental, Benevis/Pippin Dental, Lakewood Dental, Mortenson Family Dental and White River Dental

Ancillary Provider Support

INAncillaryProviderSupport@CareSource.com

Home Health, Hospice, Durable Medical Equipment, Skilled Nursing Facilities



Health Partner Engagement Representatives – Behavioral Health Resolution Specialist

Amanda Denny

Behavioral Health Resolution Specialist

Northern Territory

765-620-6722

Amanda.Denny@CareSource.com

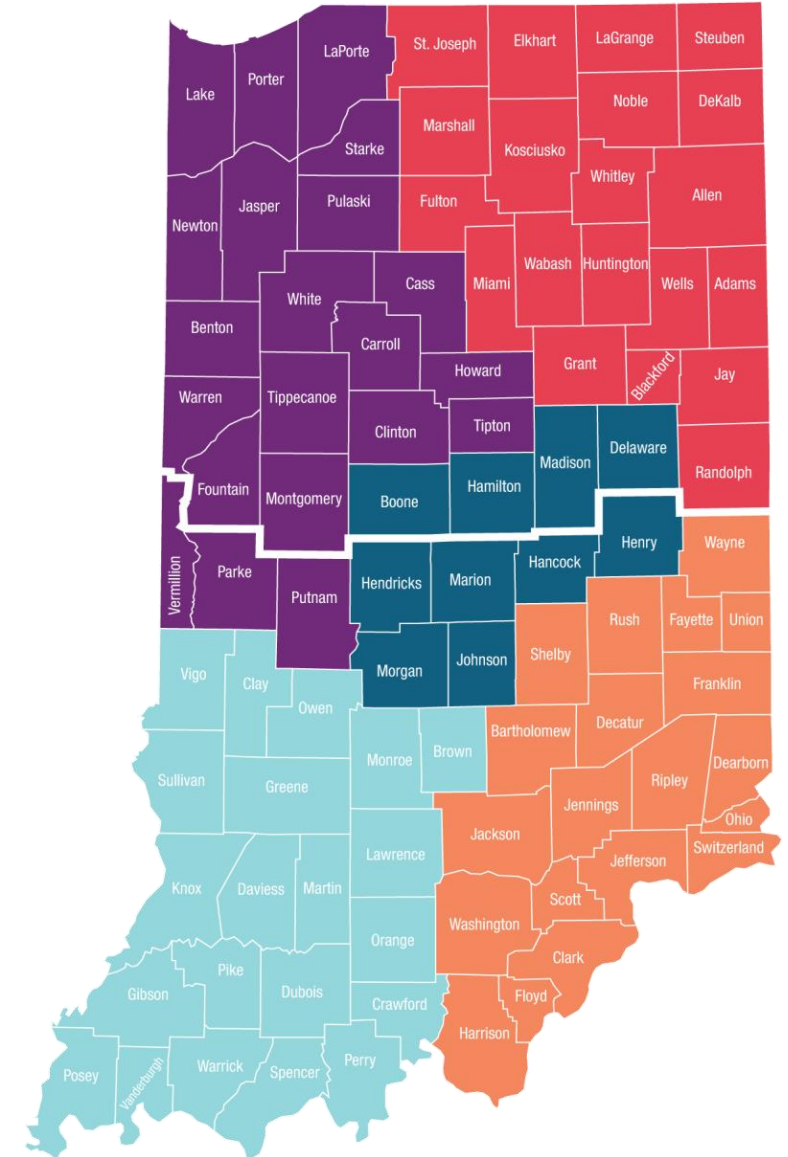
Stephanie Gates

Behavioral Health Resolution Specialist

Southern Territory

317-501-6380

Stephanie.Gates@CareSource.com



Evaluation QR Code



Presented by:

CareSource Health Partner Engagement Team

Thank You

OCTOBER 6 – 8, 2026

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